Health and Human Services Commission
Medical Care Advisory Committee (MCAC)

November 10, 2016
Meeting Minutes

Members Present:	**Members Absent:**
Gilbert Handal, MD, Chair	Cynthia Jumper, MD
Colleen Horton, Vice Chair	Elvia Rios
Salil Deshpande, MD	Donna Smith, PT
David Webster, MD	
George Smith, DO	
Doug Svien	
Mary Helen Tieken, RN	
Edgar Walsh, R. Ph	
William Galinsky, HPAC Representative	

1. **Opening comments - Gilbert Handal, MD, Medical Care Advisory Committee Chair**

   Dr. Handal called the meeting to order at 9:05 a.m. and based upon the members in attendance, a quorum was present.

2. **Comments from the Associate Commissioner for Medicaid and Children's Health Insurance Program (CHIP) Services Department, Jami Snyder, Health and Human Services (HHS)**

   Jami Snyder shared a presentation of the post transformation Medicaid and CHIP Services Department organizational structure to give a sense of the functions integrated into the Medicaid and Chip Services Department (MCSD) and what is being done to maximize the integration opportunities.

   Ms. Snyder discussed what is being done in MCSD to delineate a set of priority projects which will frame the department's work through 2017 and beyond.

   Six areas are defined:
   - Cultivating employment development and engagement to foster a culture of learning to be extended to stakeholders.
   - Facilitating meaningful stakeholder engagement and input into the deliberation processes and ensuring that stakeholder concerns are recognized and incorporated into decision making within the Medicaid and CHIP Services Department.
   - Fostering the expansion of managed care and the advancement of the Texas managed care model. An important component of that is securing the longer term extension of the current 1115 waiver. The waiver acts as the vehicle for managed care in Texas, the uncompensated care pool as well and the DSRIP program which is an important delivery system vehicle within the Texas Medicaid system.
   - Maximizing the use of data to drive decision making. MCSD was legislatively mandated to establish a data analytics team which has fostered the focus on data.

- Ensuring on-going compliance with Federal and State mandates, most notably the full integration of the new Medicaid managed care rules into contracts and policies.
- Stabilizing the Medicaid and CHIP operational and administrative infrastructure. Medicaid/CHIP has moved very aggressively into managed care over the last five to six years, as there is now real opportunity for shoring up the infrastructure around the managed care model.

Dr. Handal questioned the relationship between the HHS pharmacy benefits management and the MCOs pharmacy benefits vendor. Ms. Snyder responded by explaining that Texas has an infrastructure that operates as a partial carve in. The managed care organizations are allowed to manage the pharmacy benefits, but they are required to use a state authorized formulary. The role of MCSD is to ensure the MCOs are actually using the formulary and providing oversight of the pharmacy benefits management organizations the MCOs contract with to ensure they are maintaining fidelity to HHSC's contractual requirements.

Mr. Walsh questioned Ms. Snyder as to who is the lead person stakeholders can talk to concerning pharmacy benefit management. Ms. Snyder responded that K. J. Scheib is the lead of the operations area and is the contact. Andy Vasquez is also the Subject Matter Expert (SME).

Ms. Horton asked if the formulary sunsets at the upcoming session and moves into managed care if there is no legislation. Ms. Horton asked for clarification the change will happen unless legislation keeps things the same. Ms. Snyder responded she will research this and the timelines involved and respond back to Ms. Horton.

Dr. Handal stated there has been much debate over generics versus brand name pharmaceuticals. Ms. Snyder agreed there has been much debate over several years. Many studies have been conducted and the debates will continue throughout the upcoming session. It is a priority area for the Texas Association of Health Plans going into session.

Jami Snyder briefly discussed the Data Analytics section which will soon transition under Strategic Decision Support (SDS) in January 2017. This change is of real benefit to the organization to ensure data provided to the stakeholders is consistent and data requests are turned around in a timely fashion.

Dr. Handal asked about t the relationship of HHS to the OIG. Jami responded the OIG lives within the larger HHS infrastructure and collaborate routinely with HHS. The OIG conducts investigations of fraud, waste and abuse in Medicaid fee for service and managed care and serves as critical partner to HHS in investigating issues from an oversight perspective. OIG is mandated to maintain an independent presence outside the HHSC, but within the larger agency infrastructure.

Dr. Handal noted providers are not receiving data needed and it is very important for HHSC to provide data directly to the providers . He expressed that without data it is difficult for providers to determine how they are individually performing. Jami agreed and noted with the advent and acceleration around value based purchasing, the exchange of data between the managed care organization and the provider is an extremely critical component. and

Salil Deshpande noted that one of the opportunities is for the providers to get the complete picture, which is not something an individual health care plan can show them. HHS has the full

picture and should therefore be the conduit for making data available. Jami expressed that HHS is making great effort in conjunction with the integration of the new managed care regulations into the contract.
Colleen Horton asked the Agency improve the website for user friendliness and ease of accessing data.

3. **Approval of August 11, 2016, meeting minutes**

Dr. George Smith motioned for approval.
Dr. Salil Deshpande seconded the motion.
The motion to approve the rule passed unanimously.

NOTICE OF INFORMATIONAL ITEMS:

4. **Outpatient Diagnostic Radiological Imaging for Rural Hospitals**

HHSC proposes amendments to the Texas Administrative Code (TAC), Title 1, Part 15, Chapter 355, §355.8061, relating to Outpatient Hospital Reimbursement. These amendments are being proposed to comply with the 2016-17 General Appropriations Act (H.B.1, 84th Leg., R.S., art. II, at II-133 (Health and Human Services Section, Special Provisions, §58)).

Section 355.8061 describes the reimbursement methodology for outpatient hospital services, including outpatient hospital imaging. Under this methodology, outpatient hospital imaging services for all hospitals except rural hospitals are reimbursed a percentage of the Medicare fee schedule with reimbursements capped at 125 percent of the Medicaid adult acute care fee for a similar service. For the purpose of this rule, rural hospitals are defined as hospitals located in a county with 60,000 or fewer persons according to the 2010 U.S. Census as well as Medicare-designated Rural Referral Centers, Sole Community Hospitals, and Critical Access Hospitals.

Prior to September 1, 2015, rural hospital outpatient imaging services were reimbursed under the same methodology as non-rural hospital outpatient imaging services. Effective September 1, 2015, Section 58 in the Special Provisions for the Health and Human Services Section of the 2016-17 General Appropriations Act (H.B.1, 84th Leg., R.S., art. II, at II-133 (Health and Human Services Section, Special Provisions, §58)) directs HHSC to expend additional funds to provide modifications to Medicaid outpatient provider reimbursements for rural hospitals to ensure access to critical services. To comply with Section 58, among other actions, §355.8061 was amended to set rural hospital outpatient imaging service reimbursements equal to non-rural hospital reimbursements plus various add-on payments. This change was estimated to increase rural hospital outpatient imaging reimbursements by approximately $1.4 million all funds per annum.

In order to preserve the increased rural hospital outpatient imaging funding authorized under Section 58, the proposed rule establishes a new reimbursement methodology for rural hospital outpatient imaging services. Under the new methodology, rural hospital imaging fees will be based on a percentage of the Medicare Outpatient Prospective Payment System (OPPS), which will de-link the rural hospital fees from the acute care and non-rural hospital

fees. This change will allow HHSC to exclude rural hospital outpatient imaging fees from reductions to acute care and non-rural hospital imaging fees.

NOTICE OF PROPOSED RULES / ACTION ITEMS:

5. **Telehealth Evaluations**

HHSC proposes amendments to Texas Administrative Code Title 1, Part 15, Chapter 354, Subchapter A, Division 33, §354.1432, relating to Telemedicine and Telehealth Benefits and Limitations. The proposed rule amendments clarify that a patient must receive an initial evaluation by a physician or other qualified healthcare professional prior to receiving telehealth services, with the exception of services to treat a mental health diagnosis or condition. The proposed rule amendments further require that a patient receive a follow-up evaluation by a physician or other qualified healthcare professional for continued receipt of telehealth services, again with the exception of services to treat a mental health diagnosis or condition. The proposed amendments permit the evaluating physician or other qualified healthcare professional to conduct the evaluation in person or through a telemedicine visit that conforms to Texas Medical Board rules in 22 TAC Chapter 174, concerning Telemedicine.

Dr. Deshpande asked if a telehealth service is behavioral health related, then does it not require a physician's initial evaluation or ongoing evaluation. Mary Haifley responded that it does not have to be in person for the initial or the follow up for a behavioral health issue. Dr. Deshpande observed that for the non-behavioral health services, the rule seems to imply that either an in person or a telemedicine evaluation would be required. Dr. Handal and Dr. Deshpande agreed the rule is unclear and the intent of the rule needs to be clarified. Ms. Haifley stated a request was received from behavioral health providers for clarification that the initial and the follow up do not have to be in person, they can be performed via telehealth services.
Dr. Webster stated that there are rules as to what Telemedicine can and cannot be. A member cannot just access behavioral health services without seeing a primary care physician first to receive a referral. Colleen asked if the exception for mental health is in statute. Mary Haifley stated that it is not.

Action on Item 5
Colleen Horton motioned to approve the rule.
Dr. Salil Deshpande seconded the motion, with clarification.
The motion to approve the rule passed unanimously.

6. **Terminology and Reference Updates**

HHSC proposes amendments to Texas Administrative Code, Title 1, Part 15, Chapter 354, Subchapter A: Division 5, §354.1069, relating to Sign Language Interpreter Services; Division 29, §354.1382, relating to Conditions for Participation; and Division 31, §354.1401, relating to In-home Respiratory Therapy Services for Ventilator-Dependent Persons and to Texas Administrative Code, Title 1, Part 15, Chapter 355:Subchapter G, §355.7001, relating to Reimbursement Methodology for Telemedicine, Telehealth, and Home Telemonitoring Services; Subchapter J, Division 5, §355.8085, relating to Reimbursement Methodology for Physicians and Other Practitioners; and §355.8091, relating to Reimbursement to Licensed

Professional Counselors, Licensed Master Social Worker-Advanced Clinical Practitioners, and Licensed Marriage and Family Therapists. The proposed amendments correct terminology, correct cross references to other sections of the Texas Administrative Code, correct cross references to statute, and make other non-substantive changes.

Dr. Handal asked for clarification about the definition of an interpreter and the different categories of interpretation from Lori Breslow and a sign language interpreter. Lori Breslow stated when you look at the list it seems overwhelming. There are reasons behind the structure. The higher you go, the skill is more sophisticated. H is the very high level situation that requires a master interpreter such as interpreting major surgery or psychological evaluations and counseling.. There are also different communication styles and modes. American Sign Language is used by some in the deaf and hard of hearing community. Oral signing is also used; also a style called English sign language. An individual has the right to request a different interpreter if the situation warrants it. The recommendation was made to refer to the website for the higher level interpreter where needed, based on the requirements of the individual and the situation.

Action on Item 6
Dr. Deshpande motioned for approval.
Ed Walsh seconded the motion.
The motion to approve the rule passed unanimously.

7. **Health Insurance Premium Payment Program**

HHSC proposes new section §354.2361, Health Insurance Premium Payment (HIPP) program, under Texas Administrative Code Title 1, Part 15, Chapter 354, Subchapter J, Division 7.

The rule is established to comply with §1906 of the Social Security Act (42 U.S.C. §1396e), enacted in the Omnibus Budget Reconciliation Act (OBRA) of 1990, to reimburse eligible individuals for their share of an employer-sponsored health insurance (ESI) premium payment when cost effective.

Texas Human Resources Code §32.0422 requires HHSC to identify and enroll an individual eligible for medical assistance in a group health benefit plan offered by an employer if it is more cost-effective for the State to pay for the individual's share of the health plan premiums than to pay for the individual's Medicaid costs. Prior to August 2015, §32.0422(k) barred HHSC from requiring or permitting an individual enrolled in such a group health plan and enrolled in the HIPP program to participate in a Medicaid managed care program, but in 2015, the Texas Legislature repealed subsection (k),S.B. 207, 84th Leg., R.S., §13(2) (2015).

The proposed rule establishes requirements applicable to Medicaid-eligible individuals with ESI applying for and participating in the HIPP program. Additionally, the rule defines the HIPP program processes for individuals and their employers providing ESI.

Colleen Horton asked how families are made aware this program is available. Deborah Keyser responded that when individuals apply for enrollment in the Medicaid program and have other health insurance, outreach can be done to the individual to see if they are interested in enrolling in the HIPP program. The majority of the outreach is done by word of mouth. An outreach and communication plan is being developed to make individuals aware of the program. The website is http://gethipptexas.com.

Jami Snyder asked if MCAC members have any insight as to how individuals can be educated about the program, guidance would be appreciated. Ed Walsh stated there needs to be communication to the providers as well as to eligible individuals. Deborah Keyser stated there are plans to have additional outreach and communication not only to individuals, but also to Medicaid providers and to employers who are providing insurance.

Colleen Horton advised the process should be made as simple as possible and HHSC be as specific as possible about the benefits. Some families fear they will lose their Medicaid if the State pays for their health insurance. Ed Walsh stated there are a lot of good aspects to the program that need to be explained clearly and advertised to those who are eligible.

Action on Item 7
Colleen Horton motioned to approve the rule.
Ed Walsh seconded the motion.
The motion to approve the rule passed unanimously.

8. **Nursing Facility Habilitation Specialized Services**

HHSC, on behalf of the Department of Aging and Disability Services, proposes an amendment, repeal, and new section in Texas Administrative Code, Title 40, Chapter 19, relating to Nursing Facility Requirements for Licensure and Medicaid Certification. The proposal clarifies the difference between rehabilitative services, which may be provided to any resident in a nursing facility, and nursing facility specialized services, which may be provided only to a nursing facility resident who is a Medicaid recipient with an intellectual or developmental disability over 21 years of age, also referred to as a "designated resident." The proposal removes all references to specialized services in Chapter 19, Subchapter N, which governs rehabilitative services, and adds requirements for nursing facility specialized services in Subchapter BB, which governs nursing facility responsibilities related to preadmission screening and resident reviews.

Colleen Horton asked if PASARR is available to children under Federal law. Terry Hernandez said that PASARR services are available to children through Texas Health Steps. Colleen said that is not clear in the rule and asked if clarification could be made to the rule. Ms. Hernandez said staff would be address the request.

Colleen questioned if prior authorization is required for speech and occupational therapy. Ms. Hernandez responded prior authorizations are required. Speech and OT prior authorization are required under the regular rehab services as well.

TESTIMONY:

Susan Murphree, Disability Rights Texas- Suggestion was made the rule be changed to reflect the current name of the organization which is Disability Rights Texas.. Language around assessments says an individual cannot have a new assessment within 180 days, other language says "significant" change in condition. Regarding access to a customized manual wheelchair, there is language which states that the person is physically and cognitively capable of using the wheelchair. Disability Rights Texas wants to protect against a conflict of interest and recommends being aware of who is doing the assessment. They have sometimes encountered resistance from nursing facilities to residents having access to wheelchairs. Disability Rights Texas recommends having an additional assessment performed.

Colleen Horton asked who determines the competency. Ms. Murphree stated she is not clear on that. Disability Rights Texas has had to get a second opinion when advocating for individuals, when said individuals were not given an opportunity to demonstrate they could use assistive equipment.

Dr. Deshpande asked for clarification regarding the timeliness of assessments. Ms. Murphree stated that the concern was regarding the timing of the assessments. Staff said that individuals can have an assessment however often one is needed; however the State will pay a facility for an assessment only once every six months.

Dr. Deshpande questioned Ms. Murphree's interpretation on the need for the patient to be cognitively intact to qualify for the customized manual wheelchair. Ms. Murphree's interpretation is that there is a presumption that a person having a cognitive or a physical disability is presumed to be incapable of using certain technology. A second opinion or an independent evaluation paid for through Medicaid would avoid the appeal process while protecting the individual's rights. Doug Svien asked for re-consideration of the 180 day timeframe for re-evaluations. Colleen Horton requested consideration for adding qualifying language to the rule.

George Smith stated that the relationship of cognitive impairment and qualifying for the customized wheelchair is wrong and he cannot support it. HHSC staff will take the concerns and comments under consideration.

Action on Item 10
Colleen Horton moved to approve the rule.
Doug Svien seconded the motion.
The motion was approved, with request HHSC take the committee's comments under serious consideration. George Smith requested the record show he voted "no", as he cannot in good conscience support the language which states that a person must be cognitively capable of using the wheelchair.

9. **Public comment**

No additional public comment was received.

10. **Proposed next meeting: February 16, 2017, at 9 a.m.**

11. **Meeting Adjourned**